



ATYPICAL ANTIPSYCHOTICS PA SUMMARY

PREFERRED	Abilify tablets and oral solution, Geodon injection (PA not required), Latuda, olanzapine tablets/ODT generic, quetiapine IR generic, risperidone tablets/ODT/oral solution generic, ziprasidone generic
NON-PREFERRED	Abilify injection (PA not required for short-acting injection), Abilify Discmelt, Abilify Maintena, clozapine/ODT generic, Fanapt, FazaClo, Invega, Invega Sustenna, olanzapine injection generic, olanzapine/fluoxetine generic, Risperdal Consta, Saphris, Seroquel XR, Symbyax, Zyprexa injection (PA not required), Zyprexa Relprevv

LENGTH OF AUTHORIZATION: 6 Months to 1 Year

NOTE:

- ❖ *Prior authorization (PA) is not required for preferred generic products (olanzapine, quetiapine IR, risperidone, and ziprasidone), clozapine or FazaClo for members that are within FDA-approved ages. For members between the ages of 5-16 using risperidone generic for autism irritability, PA is not required if the ICD-9 code of 299.0 is provided on the prescription for the pharmacy to enter at the point-of-sale.*
- ❖ *Prior authorization is not required for brand short-acting injections (Abilify, Geodon, Zyprexa). Generic olanzapine short-acting injection requires PA with a written letter of medical necessity stating the reasons the brand Zyprexa short-acting injection is not appropriate for the member.*
- ❖ *If olanzapine/fluoxetine generic is requested and approved, the PA will be entered for Symbyax brand. If clozapine ODT generic is approved, the PA will be entered for the FazaClo brand.*
- ❖ *For all products requiring PA, a monitoring plan for safety and effectiveness is required.*
- ❖ *For **all** members younger than FDA-approved ages, PA must be requested by completing the Atypical Antipsychotic Prior Authorization Request Form and **faxing to Catamaran at 888-491-9742**. Letter of medical necessity information should include diagnosis, medical and medication history, improvement in symptoms while on medication, monitoring plan and any other information or documentation supporting the use of the medication.*
- ❖ *The Atypical Antipsychotic PA Request Form is located at <http://dch.georgia.gov/prior-authorization-process-and-criteria>.*
- ❖ *For medications requiring PA, an extension of therapy may be requested for members that have been on therapy and are being tapered off of medication for discontinuation, for members that have been on therapy and whose PA is under review for age appropriateness, and for members that have been on therapy and are being referred to a psychiatrist and are awaiting an appointment.*



- ❖ *Physicians discharging a member from an inpatient facility stable and responding to a non-preferred agent should request PA as part of the patient's discharge planning.*
- ❖ *If an injectable medication is being administered in a physician's office or clinic then it must be billed through the DCH physician's injectable program and not the outpatient pharmacy program. Information regarding the physician's injectable program can be located at www.mmis.georgia.gov/portal.*

PA CRITERIA:

For Clozapine Generic, FazaClo (brand and generic), Olanzapine Generic (tablets, ODT), Risperidone Generic (tablets, ODT, oral solution), Quetiapine IR Generic and Ziprasidone Generic

- ❖ *Prior authorization for members within FDA-approved ages is not required.*

For Abilify Tablets

- ❖ *For members 10 years or older with a diagnoses of Bipolar Disorder, must demonstrate prior use (for at least a thirty day treatment period) of at least one of the preferred generic drugs within the last 12 months or physician must provide clinical justification as to why the preferred generic drugs are unacceptable therapy for the member.*
- ❖ *For members 13 years or older with a diagnosis of Schizophrenia, must demonstrate prior use (for at least a thirty day treatment period) of at least one of the preferred generic drugs within the last 12 months or physician must provide clinical justification as to why the preferred generic drugs are unacceptable therapy for the member.*
- ❖ *For members 6-17 years old with a diagnosis of Irritability Associated with Autism, must demonstrate prior use (for at least a thirty day treatment period) of at least one of the preferred generic drugs within the last 12 months or physician must provide clinical justification as to why the preferred generic drugs are unacceptable therapy for the member.*
- ❖ *For members 18 years or older with a diagnosis of Adjunctive Therapy for Major Depressive Disorder, documentation should be submitted of an inadequate response to at least 3 antidepressants (one of which must be an SSRI).*

For Fanapt

- ❖ *For members 18 years or older with a diagnosis of Schizophrenia, must demonstrate prior use (for at least a thirty day treatment period each) of at least 3 of the preferred generic drugs AND Abilify and Latuda within the last 12 months or physician must provide clinical justification as to why these medications are unacceptable therapy for the member.*

For Invega

- ❖ *For members 18 years or older with a diagnosis of Schizophrenia, must demonstrate prior use (for at least a thirty day treatment period each) of at least 3 of the preferred generic drugs AND Abilify and Latuda within the last 12 months or physician must provide clinical justification as to why these*



medications are unacceptable therapy for the member. For members 12-17 years old, must demonstrate prior use (for at least a thirty day treatment period each) of at least 2 of the preferred generic drugs AND Abilify or physician must provide clinical justification as to why these medications are unacceptable therapy for the member.

For Invega Sustenna

- ❖ Members must be 18 years or older, have a diagnosis of Schizophrenia and be under treatment by or in consultation with a psychiatrist. In addition, documentation must be submitted to demonstrate one of the following: the member has already been started and stabilized on this medication, member has history of noncompliance or member is unable to swallow oral dosage forms.

For Latuda

- ❖ For members 18 years or older with a diagnosis of Schizophrenia, must demonstrate prior use (for at least a thirty day treatment period) of at least one of the preferred generic drugs within the last 12 months or physician must provide clinical justification as to why the preferred generic drugs are unacceptable therapy for the member.

For Olanzapine Short-Acting Injection Generic

- ❖ A written letter of medical necessity is required stating the reasons the brand Zyprexa short-acting injection is not appropriate for the member.

For Risperdal Consta

- ❖ Members must be 18 years or older, have a diagnosis of Bipolar Disorder or Schizophrenia and be under treatment by or in consultation with a psychiatrist. In addition, documentation must be submitted to demonstrate one of the following: the member has already been started and stabilized on this medication, member has history of noncompliance or member is unable to swallow oral dosage forms.

For Saphris

For members 18 years or older with a diagnosis of Bipolar Disorder or Schizophrenia and have difficulty swallowing regular oral dosage forms or need monitoring by caregiver to ensure compliance, must demonstrate prior use (for at least a thirty day treatment period) of risperidone ODT generic or olanzapine ODT generic within the last 12 months or physician must provide clinical justification as to why the preferred ODT generic drugs are unacceptable therapy for the member. For members 18 years or older with a diagnosis of Bipolar Disorder or Schizophrenia and are able to swallow regular oral dosage forms, must demonstrate prior use (for at least a thirty day treatment period each) of at least 3 of the preferred generic drugs AND Abilify and Latuda (Latuda only applies to schizophrenia; not approved for bipolar disorder) within the last 12 months or physician must provide clinical



justification as to why these medications are unacceptable therapy for the member.

For Seroquel XR

- ❖ For members 18 years or older with a diagnosis of Bipolar Disorder or Schizophrenia, physician must submit documentation of allergies, contraindications, drug-drug interactions or a history of intolerable side effects to the *inactive* ingredients of quetiapine IR generic and must demonstrate prior use (for at least a thirty day treatment period each) of at least 2 of the other preferred generic drugs AND Abilify and Latuda (Latuda only applies to schizophrenia; not approved for bipolar disorder) within the last 12 months or physician must provide clinical justification as to why these medications are unacceptable therapy for the member.
- ❖ For members 18 years or older with the diagnosis of Adjunctive Therapy for Major Depressive Disorder, prior use of at least 3 antidepressants (one of which must be an SSRI) is required.

For Symbyax or Olanzapine/Fluoxetine Generic

- ❖ For members 18 years or older with a diagnosis of Bipolar Disorder, an atypical antipsychotic and an antidepressant should be used as two separate products.
- ❖ For members 18 years or older with a diagnosis of Treatment-Resistant Major Depressive Disorder, prior use of at least 3 antidepressants (one of which must be an SSRI) is required.

For Zyprexa Relprevv

- ❖ Member must be 18 years or older, have a diagnosis of Schizophrenia and be under treatment by or in consultation with a psychiatrist. In addition, documentation should be submitted to demonstrate one of the following: the member has already been started and stabilized on this medication, member has a history of noncompliance or member is unable to swallow oral dosage forms.

For Abilify Discmelt or Oral Solution

- ❖ The tablet oral dosage formulation should be used. Exceptions may be made for the following reason(s), if the member meets the criteria for the tablet oral dosage formulation: members with difficulty swallowing regular oral dosage forms, needs monitoring by caregiver to ensure compliance, or dose cannot be obtained with tablet formulation.
- ❖ Physicians requesting Abilify Discmelt must also provide clinical justification as to why preferred risperidone ODT generic or olanzapine ODT generic is unacceptable therapy for the member. Physicians requesting Abilify oral solution must also provide clinical justification as to why preferred risperidone oral solution is unacceptable therapy for the member.



For Abilify Maintena

- ❖ Member must be 18 years or older, have a diagnosis of Schizophrenia and be under treatment by or in consultation with a psychiatrist. In addition, documentation should be submitted to demonstrate one of the following: the member has already been started and stabilized on this medication, member has a history of noncompliance or member is unable to swallow oral dosage forms.

QLL CRITERIA:

- ❖ *For Clozapine, Olanzapine, Quetiapine IR, Risperidone, Ziprasidone:* An authorization to exceed the QLL may be granted if the member's dose is being titrated due to initiation of therapy. The physician should submit faxed documentation of the proposed titration schedule.
- ❖ Additionally, for *olanzapine 20mg*, an authorization to exceed the QLL may be granted if physician submits faxed documentation of evidence of refractory schizophrenia and evidence that the member is being monitored for increases in weight, blood glucose, and lipid panel.
- ❖ For *low-dose quetiapine IR* (25mg at doses of 1 or 2 tablets per day or 50mg at dose of 1 tablet per day), the physician must submit a written letter of medical necessity. The member must also not be using another strength of quetiapine IR, an antidepressant, or an antipsychotic.

EXCEPTIONS:

- ❖ Physicians can request approval for members which have been started and stabilized on a non-preferred product for a reasonable period of time prior to becoming Medicaid eligible or during hospitalization. It should be noted that use of samples does not constitute stabilization.
- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process for members within FDA-approved ages may be initiated by **calling Catamaran at 1-866-525-5827**.
- ❖ The Prior Authorization process for members younger than FDA-approved ages must be initiated by completing the Atypical Antipsychotic Prior Authorization Request Form and **faxing to Catamaran at 1-888-491-9742**. The Atypical Antipsychotic Prior Authorization Request Form can be found at <http://dch.georgia.gov/pharmacy> > Prior Authorization Process and Criteria or directly at <http://dch.georgia.gov/prior-authorization-process-and-criteria>.

PA and APPEAL PROCESS:

- ❖ For online access to the PA process please go to www.mmis.georgia.gov/portal, highlight the pharmacy link on the top right side of the page, and click on "prior approval process".



QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limit please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.